

## **CHAPTER X: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

In this chapter we summarize results of interviews with 207 informal kinship caregivers, 56 children in their care, and 30 birth parents. The interviews with caregivers were conducted in their homes or another location of their preference. The interviews incorporated established measures of child functioning, caregiver stress, family functioning, social support, family resources, and a simple measure of stability of living arrangement. These interviews also included collection of demographic data describing the caregiver, child, and family, as well as open-ended questions that solicited caregivers' perceptions of the reasons the child is in kinship care, the strengths of their family, relationships between children, parents and caregivers, sources of support and help, and service needs that the family may have. We also conducted follow-up interviews with over 80% of these caregivers six, twelve and eighteen months later, using the same measures used in the initial interview.

Interviews with children were conducted at a single point in time. These qualitative interviews explored their conceptions of family, and perceptions of belonging, permanence, and stability. Children were eligible to participate in interviews if they were eight years of age or older and were the focus of the child behavioral functioning measure in the caregiver interviews. Interviews with parents were also conducted at a single point in time to understand their views of kinship care and their current and future roles in the lives of their children.

This chapter begins with a summary of key findings and the conclusions we draw from these findings. We end with a number of broad recommendations for policy, practice and future research.

## Summary and Conclusions

The overwhelming majority of kinship caregivers who completed the initial interview were female (96%) and African American (89%). Twenty-five percent of the caregivers were married and the remainder described their status as widowed, single or separated. They ranged in age from 22 to 72 years of age. Caregivers' levels of formal education ranged from some grade school to college graduation and completion of some graduate or professional school classes. The largest category of caregivers (41%) had completed high school and some college or trade school classes. Over 62% reported that they were not employed; 27% were employed full time and 11% part time. Self-reported family income ranged from less than \$5,000 per year to more than \$50,000, with nearly 71% reporting incomes under \$20,000 per year. The mean number of children in the home ranged from 2.85 at wave 1 to 2.66 at wave 4. This included the caregiver's own children and relatives' children. The number of children living in the home ranged from 1 to 10 at wave 1 and from 0 to 13 at wave 4.

The children who were the focus of the Child Behavior Checklist (CBCL) and Parenting Stress Index (PSI) ranged in age from 18 months to barely 11 years of age at wave 1, consistent with the sampling criteria. At the time of the initial caregiver interview, the length of time that the children had lived in the kinship caregiver's home ranged from one month to 11 years. The sample was nearly evenly split between male and female children. The racial/ethnic characteristics of the children closely reflected those of the caregivers. Over two-thirds of the children were living with their grandparent or great-grandparent; 27% with an aunt, uncle, great-aunt or great-uncle; others with older siblings, cousins or other relatives. Nearly 50% of the caregivers reported that they were legal guardians of the focus child at wave 1, 56%, 62% and 65% at waves 2, 3 and 4 respectively. The absolute number of kinship caregivers who became

legal guardians of focus children in this study also increased from 102 at wave 1 to 110 at wave 4, even though 38 fewer caregivers completed interviews at wave 4 compared to wave 1.

### ***Reasons, Caregiver Motivations, and Pathways to Kinship Care***

Caregivers were asked to explain how they became responsible for the care of a relative's child. Their responses to this question tended to describe a dynamic process involving three simultaneously occurring influences: (1) the reasons that the child's biological parents were unable to care for the child, (2) the caregiver's motivations for providing kinship care, and (3) various pathways that children took to get to the current kinship caregiver's home.

Caregivers described many reasons that the biological parents were unable to care for the children, which we organized into eight categories: (1) parental substance abuse/addiction; (2) parental neglect, abandonment or abuse; (3) parental incarceration; (4) young and inexperienced parents; (5) unstable home life/homelessness; (6) lack of resources and general inability; (7) parental mental illness; and (8) parental physical illness or death.

When asked to describe how they became involved in raising a relative's child, some caregivers responded by describing what motivated them to assume this responsibility. Five primary motivations were most clearly identified: (1) to keep the children with family and out of the foster care system; (2) to keep the children safe, ensure their well-being, and provide them with a sense of belonging; (3) a sense of obligation or family legacy; (4) love; and (5) in response to a spiritual influence.

We have identified seven pathways from the stories that caregivers shared with us: (1) the caregiver "stepped in" without being asked, (2) the mother asked, (3) the father asked, (4) the child asked, (5) DCFS asked/diverted the child from the child welfare system, (6) another relative asked, (7) and multiple/complex pathways.

### ***Child Behavioral Functioning, Caregiver Stress, Family Functioning, Resources, Social Support***

Results of the univariate analysis of the main variables in this study indicate considerable variance in the behavioral functioning of the children who were the focus of the caregiver's child behavior checklist ratings, in the parenting stress experienced by the caregiver, in family functioning, adequacy of family resources, and social support. The multivariate analyses indicate that caregiver stress and the child's age are consistent predictors of child internalizing, externalizing, and total behavior problems; caregivers reporting higher levels of stress and caring for older children tend to report that these children display higher levels of behavior problems. Caregiver age was also a significant predictor of internalizing and total child behavior problems in most models, but perhaps not in the direction that might be expected. Younger caregivers tended to report higher levels of internalizing and total behavior problems than older caregivers. Caregiver race is a consistent predictor of level of internalizing behavior, somewhat so for total behavior problems; less so for externalizing behavior problems; African American caregivers tend to report lower levels of behavior problems compared to others. Family functioning is a significant predictor of internalizing and total behavior problems in models that include all four waves of data, and only marginally so for externalizing behavior. Less healthy family functioning is associated with higher levels of behavior problems.

Social support is a statistically significant predictor of internalizing behavior problems and a marginally significant predictor of total behavior problems in the analysis that includes all four waves of data, but not in the analysis of first wave data. However, more helpful social support is associated with higher levels of internalizing and total behavior problems, suggesting that it is the child's behavior problems that may contribute to social support rather than social support influencing behavior problems. Perhaps caregivers of children with greater internalizing

problems reach out for and receive more assistance from informal and formal support systems. Further examination is needed to understand these associations.

The child's externalizing behavior problems, family resources, and family functioning are statistically significant predictors of caregiver stress. We also discovered an interesting interaction between family functioning and family resources: for families with more adequate family resources, healthy family functioning is associated with lower levels of caregiver stress, but for families with less adequate resources, the inadequate resources seem to have a consistent impact resulting in higher levels of caregiver stress regardless of family functioning. While social support is not a statistically significant predictor of caregiver stress in any of the models, we do have some concerns about the social support measure. Respondents are asked to rate the helpfulness of individual listed in the family support, however, caregivers could select "not available." Not available was treated as a missing value and the scale score was computed by summing all items and dividing by the number of items rated, excluding those rated "not available." Further analysis is required to determine whether availability of social support is associated with caregiver stress and other variables in this study.

### ***Stability of the Child's Living Arrangement***

The majority of the children who were the focus of caregiver interviews remained in the care of the same relative during the course of this study. We do not know the whereabouts of 19 of the children, since we lost contact with the family prior to completing the four interviews. Of the 31 children that we know left the caregiver's home, 20 moved in with their biological mothers, 1 with the biological father, four with another relative, one returned to an aunt who had previously adopted the child, and two were adopted by friends of the family. Only two children were taken into the custody of the formal child welfare system. We do not know where one child is living, but we do know that the caregiver moved out of state without the child.

The good news seems to be that the majority of children in this study continued to live with family members for the 18 months that we knew them and that moves from the caregiver's home tended to be to homes of their parents or other relatives. However, from the perspectives of some caregivers, moving in with a biological parent was not always considered to be positive. While some caregivers were happy for the children and parents, expected success and supported the parent and child to help ensure success, others were concerned that the parent would not adequately care for the child and that the child would return. Three of the 31 children who left caregivers' homes did return before the fourth wave interview. We have no idea how many children may have left the caregivers' homes or left and then returned following our last interview with them.

### *Caregiver Views of Relationships between Parents, Children and Caregivers*

Caregivers reported considerable variability in the frequency of their contact with the parents of the children in their care and the frequency of contact between the parent and their children, ranging from no contact to daily contact. Roughly 20% of caregivers reported no contact with the mothers and a slightly higher percentage of caregivers reported daily contact with the mothers. Approximately 50% of caregivers had no contact with the father and 5% (wave 1) to 11% (wave 2) of caregivers had daily contact with the fathers. Frequency of contact between the children and their parents was similar to the frequency of contact between the caregivers and parents.

There is also considerable variability in caregivers' ratings of the quality of these relationships. Over one-third of caregivers rated their own relationship with the focus child's mother as very friendly with no conflict or only minor conflict. Nearly as many caregivers rated their relationship with the child's father in the same way. Eleven percent (wave 4) to 17%

(wave1) of caregivers categorized their relationship with the mother as not friendly with some or much conflict and between 5% (waves 2, 3, 4) and 9% (wave 1) of caregivers described their relationship with the father in this way. Some caregivers expressed frustration with the parent's drug use or other problems that prevented them from assuming the role of the child's primary caregiver. Other caregivers praised the parents for their efforts to deal with challenges they faced (e.g. progress made in drug treatment) or their involvement in their children's lives, their love for their children, etc. Many caregivers expressed their own disappointment, frustration and sometimes anger with parents for disappointing children or failing to assume responsibility for the children. Others feared that the parents might take their children back and not adequately care for them. Caregivers often expressed understanding of the challenges faced by the parents related to substance abuse, mental health, or becoming a parent at a young age.

Many caregivers described how important the parents are to their children and seemed to honor and encourage this relationship. These caregivers provided detailed examples of the positive aspects of the parent-child relationship. It is interesting that caregivers identified positive aspects of the parent-child relationships even when the caregiver seemed to hold out little hope that the parent would assume primary caregiving responsibility for the child. While frequent contact between parents and children was often associated with positive relationships, this was not always true. Some parents were described as maturing and demonstrating increasing responsibility for their children, while others were described as having child-like relationships with their children, similar to peers or siblings. Caregivers described a role reversal in some relationships, with children worrying about their parents and in some ways acting as the parents' caregivers. A number of caregivers mentioned that the children missed their parents greatly and the parents of some of these children took little interest in them. Some children were openly

angry with their parents and confronted them about their failure to do the things necessary to care for them. Other caregivers described the children's feelings toward their parents as neutral or ambivalent.

Many caregivers also discussed their own relationships with the children. Many caregivers described strong, positive relationships with the children, some going so far as to describe the children as blessings or gifts. Others described the relationship as close and caring, while also frustrating and overwhelming at times. A few caregivers indicated that it was difficult developing close bonds with the relatives' children. Others described the additional responsibility they have assumed in relationship to their own hopes and dreams for the children and their commitment to ensuring a positive future for them.

#### ***Caregiver Views of the Strengths, Challenges, Service Needs and Caregiver Recommendations***

Kinship caregivers described a number of strengths as well as challenges faced by the related children in their care. Some children were described as having easy going temperaments. Some were described as loving children who were expressed gratefulness to their caregivers for raising them and understanding and forgiveness toward their parents. Some caregivers identified strengths that children displayed through improving behavior or academic success. Challenges for some children included academic problems, emotional/mental health issues, physical health problems, and behavior problems.

Caregivers also identified their own strengths and challenges. Strengths included a positive view of the caregiving experience, the ability to recognize progress, willingness to make sacrifices, a natural helping tradition in their families, spirituality that serves as a source of strength and support, and commitment to providing a positive, safe, and stable environment for the child. Other strengths included a high level of involvement and investment in the child's life,

experience with children and an understanding of children's needs. A few caregivers identified their knowledge of resources and how to access them as strengths, and some caregivers identified their own aspirations and achievements as strengths.

Caregivers also identified a number of challenges that they experienced. These included personal sacrifices they have made to care for a relative's child, challenges with the child's biological parent, and emotional challenges that accompany caring for a relative's child. Some caregivers indicated that they have given up too much. Some stressed that it is more difficult raising grandchildren or other relatives than it was raising their own children and that it has had an impact on relationships with intimate partners and other family members. Many caregivers described the financial challenges as well as other hardships, stress, and physical health challenges that complicate the task of raising a relative's child.

One hundred fifty-one caregivers identified at least one service that they or their family members received but 56 could not identify any services received. All 207 caregivers identified at least one service that they or their family members needed and were not receiving. Many caregivers indicated that they lacked knowledge of services and supports that might exist or how to access them.

When reflecting on their own experience, kinship caregivers fell into one of six categories: (1) those who would recommend that families care for their kin, (2) those who indicate that they would do it again, (3) those who would do it again despite the challenges, (4) those who are unsure whether they would do it again, and (5) those who indicate they definitely would not care for a relative's child again. The sixth group of caregivers indicated that they would give it careful consideration before caring for a relative's child because they do not

believe that it should be necessary—believing that parents should be able to raise their own children.

The caregivers in this study provided a great deal of advice to those who might consider becoming a kinship caregiver. They stressed that potential caregivers should understand that caring for a relative's child requires a high degree of personal sacrifice. They recommended that potential caregivers take care of themselves and be aware of their own limitations, be prepared for a variety of difficulties they will encounter, and be committed to the child—since this may be a very long-term arrangement. Some caregivers recommended participation in support groups. Some caregivers warned of the roller coaster ride that is the relationship with some parents of children in kinship care. Some caregivers recommended getting legal custody of the children while others cautioned against this, indicating that taking guardianship makes families ineligible for some services. A number of caregivers emphasized supporting children's relationships with their parents and not saying anything bad about the parents to the children. Many caregivers stressed that the role of the caregiver is to give the child a stable life and a good future and recommended being loving, patient, understanding and honest in interactions with the relative's children.

Caregivers also made recommendations to policy makers. First and foremost caregivers recommended financial support for kinship caregivers and their families. Caregivers also recommended that policy makers find a way to ensure that relative caregivers know about services and supports that might be available and that kinship caregivers can access these services. Finally, caregivers stressed that policy makers and the general public need to keep the focus on the needs of children who live with relatives, and that they support kinship caregivers so they can support the children.

### *Children's Views*

Interviews were conducted with 56 children who were living with the kinship caregivers in this study. These children were the focus of the CBCL and PSI in the caregiver interviews and were at least eight years old at the time they were interviewed. The interviews were semi-structured, guided by a number of open-ended questions. The interviews were audio taped, transcribed verbatim, and analyzed using Atlas.ti software and a grounded theory framework. The purpose of the interviews was to explore the children's views of family; their sense of safety, belonging, stability and permanence; and their views about living with a relative other than a parent.

To understand how children viewed "family" we asked them to draw a family tree and to list the names of each person in their family on limbs of the tree. Children defined family broadly, listing between 8 and 33 members including nuclear and extended maternal and paternal family members living in and outside of the caregiver's household, fictive kin, and sometimes pets, friends and teachers. The majority of children appeared to feel that they were part of a large and loving extended family. Children described things that caregivers did that made them feel welcome in their homes: (1) meeting their physical and material needs, (2) meeting their emotional needs for affection and recognition, (3) teaching and supporting them, (4) respecting the children and being proud to care for them, and (5) participating in activities with the children and taking them on outings.

We asked children to describe the place they felt most at home. The majority of children felt most at home with the current caregiver but more than 20% of the children indicated that they felt most at home with another relative they were not currently living with such as their mother, father, aunt, sister or grandmother. A few children indicated that they felt most at home with a parent and the current caregiver. When asked what made them feel at home, children

described various daily and recreational activities, the safe and comfortable atmosphere of the home, contact with many family members, gifts they receive on birthdays, the food that is provided, or their personal possessions. We also asked children what they liked and disliked about living with the current caregiver. Children gave similar answers to their descriptions of what made them feel at home, indicating that they liked activities they engaged in, interaction with the caregiver and other extended family members, the way the caregiver provides for the child, and the atmosphere of the home. Twenty-one of the children were able to identify at least one thing they did not like about living with the current caregiver. These dislikes fell into five categories: (1) absence of the parents, (2) conflicts with household members, (3) the community or household environment, (4) discipline issues, and (5) activities that they disliked.

To determine their sense of stability and permanence in their caregivers' homes, children were asked to tell us where they were living on their last birthday and where they expect to be living on their next birthday. Three quarters of the children were residing with their current caregiver on their last birthday. Three children (5%) were living with a different relative on their last birthday. Information is missing for eleven children (20%), either because the interviewer did not ask the question or we were unable to determine where the child was living based on the child's response to the question. Nearly half (48%) of the children expected to be living with their current relative on their next birthday, five children indicated that they would be living in a different location on their next birthday but did not indicate who their caregiver would be, and one child indicated she wanted to live anywhere as long as there was a family member there. Eight children felt that they would be living with a different relative at the time of their next birthday, six with their biological mother, one with an aunt and one child thought he would be living with his sister. Six children indicated that they were uncertain with whom they would be

living on their next birthday. Information is missing for nine of the children, because the interviewer did not ask the question or we were unable to determine where the children felt they would be living based on their response to the question.

We also asked children where and with whom they would like to be living in the future. Twenty-three of the children (41%) indicated that they prefer to live with their current caregivers; however, 15 of these children specified other relatives and friends they wished would also be living in the home with the caregiver. Sixteen children (28.6%) said they wanted to live with one or more of their parents: 6 children (10.7%) indicated that they prefer to live with their mother; 3 (5.4%) with their mother and father; 2 (3.6%) with their mother and siblings; 2 (3.6%) with mother, father and siblings; 1 (1.8%) with mother, father and grandmother (not the current caregiver); 2 children (3.6%) preferred to live with their fathers; and one child specified a preference for living with the father and great-grandmother. Two children (3.6%) said they wanted to live with their siblings. Five children (8.9%) indicated that they wanted to live with a variety of other relatives (e.g. aunts, uncles, other than current caregiver). Three children (5.4%) indicated that they wanted to live with “family” without specifying the family members. Most children seemed to have a feeling of security and a belief that they would have a place to live in the future that included family. One of the children (1.8%) was clearly less certain of the future but wanted to live with the current caregiver or mother. Six children (10.7%) either did not specify who they would like to live with but described a living environment that is safe and with good people or mentioned a preference for living with someone other than family (e.g. teacher, friends, etc).

## *Parents' Views*

We conducted semi-structured, in-depth interviews with 30 birth parents of children in kinship care, 27 mothers and 3 fathers. The interviews were audio taped, transcribed verbatim and analyzed using Atlas.ti software and grounded theory. Parents described reasons they were unable to care for their children that included teen parenthood, lack of adequate housing, drug use, job loss, mental health problems, psychological trauma, disrupted or turbulent relationships with intimate partners. A couple of parents indicated that their children were living with relatives so the parents were able to work, complete school, or just “get myself together.”

Parents described their current roles in the lives of their children. Some parents reported frequent, active involvement that included participation in a full range of parenting tasks and responsibilities. Others primarily described recreational activities. Parents also described the roles they would like to play in their children’s lives in the future. A number of parents indicated that they would assume full responsibility for raising their children, while others focused on developing a friendship or close confidant relationship with their children.

Parents described a range of feelings that they experience when they are with their children and when they are away from them. Feelings of loneliness and loss were expressed when not with their children and feelings of joy and pride when with the children. A couple of parents indicated that they were inspired or enlightened by their children. Some parents admitted to feeling frustrated with their children’s behavior and their own lack of patience at times.

We asked parents to share their positive and negative views of kinship care. Many parents indicated that they were happy that their children were living with people who loved them, the children were safe and well cared for, they were doing better in school and they were getting the opportunity to get to know their relatives. Negative views included loss of the parent

role and the fear of being forgotten by their children. Some parents indicated that they were fearful of “oversteppin’ my bounds” by asserting the parent role, possibly causing conflict with the kinship caregiver. Several parents indicated that they were thankful that the relative was caring for their children and some acknowledged the burden that the relative caregiver had assumed.

Parents described their future goals and dreams for their children which included academic success, responsible behavior, avoiding gang involvement, and having a happy life. Many parents described their plans to support their children’s success by encouraging them, advocating for them and by getting their own lives in order and providing a positive example for their children. Parents described their own strengths, limitations and challenges in caring for their children and also described a range of relationships that they have with their children and the caregivers of their children.

### **Conclusions: Potential Protective Factors for Children in Informal Kinship Care**

The results of this study suggest that lack of family resources, unhealthy family functioning, and caring for a child with more serious behavior problems may be risk factors for caregiver stress. These results also suggest that a high level of caregiver stress and family dysfunction may be a risk factor for child behavior problems. One of the most important potential protective factors seems to be adequate family resources (financial and material resources, time). Once a family’s basic needs are being met, then healthy family functioning is likely to reduce caregiver stress. We are not really clear on the direction of the relationship between caregiver stress and child behavioral functioning; we are not able to tell how much a caregiver’s stress can be reduced by improving child behavior or how much a child’s behavioral functioning can be improved by reducing caregiver stress (through enhancing financial and

material resources, for example). We are clear that the child's behavior, caregiver stress, family resources, and family functioning are associated and all should be considered when creating policies and programs to support informal kinship caregiving families.

Findings also suggest that reasons that parents are unable to care for their children can be thought of as risk factors for the children. For example, parental substance abuse, criminal activities, incarceration, illness create stress for children and their caregivers. Some of the stories that individual caregivers shared with us also suggest that the commitment that informal kinship caregivers and their family members have to keeping the children within the family is probably in and of itself a protective factor. Caregiver's motivations to care for the children suggest several familial level protective factors: caregiver's commitment to and love of the children, their commitment to keep their families together, a legacy of shared family caregiving, and spirituality for some. Pathways to kinship care also suggest several protective factors, from the determination of caregivers to initiate the kinship care arrangement because of their concerns about the child to the parents', children's, or other relatives' willingness to ask the caregiver to help and the caregivers' willingness to consider this request.

Results suggest that risk factors for children in kinship care include lack of contact or strained relationships with birth parents and relationships with relative caregivers that are not close, as well as conflict between the children's parents and relative caregiver. On the other hand, positive relationships with birth parents, combined with frequent contact, and friendly relationships between the parents and caregiver may be protective factors. We have not empirically tested these assumptions in this study in any detailed manner. However, preliminary analyses do suggest that conflict in the parent-caregiver relationship is associated with higher levels of caregiver stress.

Qualitative data from the perspective of caregivers, children and parents suggest that a number of child and caregiver strengths seem to be factors that both promote the health of the child, caregiver and family and buffer the harmful effects of risks and challenges associated with kinship care. Interviews with children suggest that a sense of belonging to a large and caring extended family is a protective factor that helps to buffer the risks that children experience when their birth parents are unable to care for them. Many of these children value not only the relationship with their current caregiver, but the relationships with their parents, siblings, cousins and other relatives as well. Responses from many of these children reveal that that they recognize and value the way that their current kinship caregiver ensures that their basic needs are met and makes the children feel valued. These responses often reveal memories of a less stable time in their life and fears that they may not be able to fully depend on their birth parents if they returned to live with them in the future. Interviews with parents indicate that some parents of children in kinship care have strong feelings of attachment and love for their children, have lofty hopes and dreams for these children, and are interested in playing a role in helping the child achieve a successful and happy life. Comments made by some children, birth parents, and caregivers suggest that the relationship between the child and parent is important to maintain and strengthen, even if there is little likelihood that the birth parent will ever assume or resume the primary caregiving role for the child.

### **Recommendations for Policy, Practice and Future Research**

In this section we make some broad recommendations for policy, practice and future research. These are by no means intended to be exhaustive. Rather they are a starting place. We hope that the information that kinship caregivers, children and parents shared with us stimulate

discussion and debate regarding policies and practices to support kinship care as well as future research directions.

### ***Policy Recommendations***

Findings of this study suggest that families caring for a relative's child need support in three broad areas: (1) financial and material resources; (2) access to specialized services, and (3) family relationships. It makes sense that the future of children in kinship care depends in large part on the healthy functioning of the relatives caring for them and their larger family systems. We also know from this research and prior research that caregiver stress is highest for families with the fewest resources. In this study, as well as prior research, we also see that caregiver stress is highest and family functioning is poorest in families with children with serious behavior problems. Our findings suggest that first and foremost policies are needed that provide financial support for relative caregivers. At a minimum we need policies that lessen the financial burden that is experienced by relatives who come forward to raise their relative's children. However, the resource needs are great. We know that kinship care is most common among families with the fewest resources, but also that families of moderate means suffer financially as well, losing their retirement savings, refinancing homes, and incurring serious debt to cover legal fees and a number of other costs associated with raising a relative's child.

Access to specialized services is also needed, particularly for families with children with serious behavioral and mental health problems. It is not a surprise that children who live with relatives are more likely to display serious behavioral and mental health problems than children in the general population. Many of these children have experienced a number of losses, traumatic events, abuse or neglect that led to their coming to live with a relative. These events and this neglect often have consequences that are displayed through behavior that can be frustrating and difficult to manage. Access to specialized services is important for these children and their

caregivers; perhaps for their entire extended family as well. Results of this study suggest that providing services to assist families in coming together, supporting each other, and resolving conflict may also be helpful, as long as financial and material resource needs are addressed first.

This research, as well as prior research, indicates that many informal kinship caregivers have considerable unmet service needs and that significant numbers of these caregivers and their families do not utilize services and resources they are eligible to receive. Qualitative data from interviews with caregivers and observations of interviewers in this study suggest that there are a number of barriers to services for kinship caregiving families: (1) lack of services that specifically meet the needs of these families; (2) lack of knowledge of services that do exist; and (3) fear of coming forward to express the need for services or to use services. A number of families were fearful that they might lose custody of the related children in their care if the formal social service system discovered that they were having a difficult time meeting the needs of these children and others in their family.

We do see the need for navigator programs to assist families in identifying and accessing services and resources that do exist that may meet their needs; the Kinship Caregiver Support Acts pending in the House and Senate propose funding for such programs. We believe that a navigator program is a necessary step in the right direction, but will not be sufficient to meet the needs of kinship caregiving families. Relying solely on a navigator program assumes that all needed services and resources currently exist and the only problem blocking access is lack of knowledge or linkage. We also see the need for the creation of comprehensive social policies and programs that currently do not exist, that provide:

- financial supports to kinship caregivers and protect caregivers and their families from serious economic costs, and

- specialized services for children, caregivers, birth parents, and other members of extended families engaged in kinship care.

Fragmented funding and eligibility criteria for services and supports for kinship caregiving families are major problems. For example, some services funded by the Department on Aging require caregivers to be at least 60 years of age, however, the average age of kinship caregivers is approximately 50 years of age. Other funding sources, like foster care subsidies, subsidized guardianship or subsidized adoption are available only to kinship caregivers of children who are or have been in the custody of the child welfare system and therefore are not available to support informal kinship care. Also, child welfare case management services available to formal kinship care are not available to informal caregivers. Policies need to address the needs of all caregivers and families, regardless of the age of the caregiver or whether the child is in the custody of the child welfare system or not.

It is also important to support kinship caregiving families regardless of the service systems that they encounter. This requires social service systems to work collaboratively to meet the needs of these families, whether the system that has primary or initial contact with the family is the Department on Aging, the Child Welfare System, the School System, Healthcare systems, the Juvenile Justice system, Adult Criminal Justice systems, or other social service systems. It is important to develop policies that provide incentives for cross-system collaboration with and on behalf of kinship caregiving families.

We also see the need to identify future needs community by community through dynamic community-based systems of support that include among its leaders kinship caregivers and other members of families involved in kinship care. This approach assumes that meeting the needs of kinship caregiving families is a community-wide shared responsibility which includes ongoing

assessment of needs, advocating for policies and programs to meet these needs, ensuring that human service professionals know and implement existing policies that provide necessary support for families, and reaching out to families that are reluctant to make their needs known.

The recommended programs need well trained and committed human service professionals. Stable funding is required to hire, train and retain these professionals. At this point in time funding for staff positions for creative programs that target informal kinship caregiving families is rare, low and unstable. Funding may be provided for demonstration projects that may last a number of years but more permanent sources of funding are required. A commitment to providing programs and services to support informal kinship caregiving families requires a commitment to adequate funding for these staff positions.

### ***Recommendations for Practice***

A number of practice innovations have been implemented in special projects or programs that serve kinship caregiving families. Among these are family group conferencing, family group decision-making, mediation, caregiver support groups, warm lines for kinship caregiving families, navigator services, and other specialized interventions for specific groups of kinship caregiving families such as those with children whose parents are involved with the criminal justice system. We applaud all of these but want to emphasize that a first step in any providing services to kinship caregiving families should be to assess their financial and material resource needs. Our research suggests that interventions with family members are more likely to be effective if financial and material resource needs are addressed first, or if meeting these needs is a top priority component of the service plan.

We also believe that human service professionals must be trained to understand the needs of kinship caregiving families, to understand the policies, programs and services that may benefit

these families as well as the eligibility criteria for these programs and services. At a minimum, human service professionals need to know who to contact and what questions to ask to identify services and resources that may be available to kinship caregiving families with whom they are working.

We do believe that it is important to reach out to kinship caregiving families who may be experiencing high levels of kinship caregiver stress, family relationship stress, and child behavior problems. These families come into contact with a variety of service systems: the school system, mental health systems, the health care system, correctional facilities, etc. It is important that these systems think broadly when encountering individuals who may be part of a kinship caregiving system. For example, caregivers who experience high blood pressure and other indicators of poor health may also be experiencing stress that is related to the caregiving situation, relationship with the parents of the children in their care, the child's behavioral functioning or financial strain brought on by the additional burden of caring for a relative's child. Child behavior problems in school might be related to conflict in the family and caregiver stress. Parents returning to the community after incarceration face a number of challenges that may be exacerbated by a stressful relationship with their children or the relative who is caring for these children. It is important that these and other service systems be educated about the prevalence of kinship care and the strengths and challenges faced by members of a family that is involved in kinship care. It is important for professionals in these different service systems to realize that the narrowly defined problem that comes to their attention may be related to broader issues that require a more comprehensive and coordinated assessment and intervention and the collaboration of several service systems.

We believe that it is important to think broadly when reaching out to support kinship caregiving families. Our research suggests that at least for some families engaged in kinship care, it is important to involve the biological parents of the children who are living with relatives. This may be helpful in building or strengthening co-parenting relationships between birth parents and the primary kinship caregivers, which may be helpful as parents assume or resume primary care of their children. However, it may also be important for parents who will never become primary caregivers for the children but may be able to maintain a relationship with the children and possibly provide support for the primary kinship caregivers. For many kinship caregiving families it is also important to engage extended family members in a plan to support the primary kinship caregivers to assist them in caring for the child and to reduce stress and burden experienced by kinship caregivers.

### ***Recommendations for Future Research***

There are a number of findings from this study that require further exploration: (1) the relationship between family resources and caregiver stress and family resources and child behavioral functioning, (2) social support and its relationship to both caregiver stress and child behavioral functioning, (3) family functioning and its relationship to child behavioral functioning and caregiver stress. The measure of family resources that we used in this study includes items that measure adequacy of financial resources as well as other basic resources, medical resources, time for self and time for family. In future analyses we will attempt to determine which of these subscales contributes to caregiver stress and we will also explore whether any of these subscales contribute to our understanding of child behavioral functioning, since the total family resource scale score did not.

We were surprised that social support was not related to caregiver stress in this study. Prior research does reveal inverse associations between social support and caregiver stress. We do have some questions about the way that we scored the Family Support Scale in this study. Like many others who have used this scale, we used the mean rating of helpfulness calculated only for the items that received a response other than not applicable, not available or no response. However, we are concerned that “not available” and “not applicable” may actually be measures of lack of support. In the future we will use a second measure of social network size that is based on the number of items in the scale that are rated something other than not applicable, not available or no response. We will include this measure of network size into our equations along with the measure of helpfulness of members of the social network (our current measure of social support). Our preliminary analysis suggests that network size may be inversely related to caregiver stress. We also plan to examine in greater detail social support that is provided by specific network members. Our preliminary analysis suggests that social support provided by the caregiver’s own children or members of a church congregation may be the most helpful and may be inversely related to caregiver stress. We will also use qualitative methods to further explore the issue of social support and what types of social support are considered to be most and least helpful to various caregivers and their families.

In future analyses we will examine various aspects of family functioning and its relationship to both child behavioral functioning and caregivers stress. We also believe that it is important also to examine the impact that kinship care has on families. Further exploration is needed to determine whether and how functioning of the larger extended family as well as the functioning of subsystems within this family affect, and are affected by, the kinship caregiving experience and the functioning of individuals within the family. We are particularly interested in

exploring the potential protective effects of parent-child and parent-caregiver relationships in relationship to child, caregiver, and birth parent outcomes and the functioning of the entire extended family system.

We also have some recommendations about the ways that research is conducted. Informal kinship caregivers are a relatively hidden population and it is difficult and expensive to design studies that can recruit a representative sample of this population. Community/household surveys are one possibility, perhaps with more detailed follow-up interviews with kinship caregiving families that are identified. However, there is no certainty that informal kinship caregiving families will identify themselves or consent to participate in this type of study. Our experience suggests that it takes considerable time to build credibility and trust with communities that would then foster participation in research studies that probe informal kinship caregiving family relationships. We do think that respondent driven sampling is worth exploring, since this type of sampling procedure has been successful in approximating representativeness in research with hard to reach populations.

We also recommend the use of multiple methods and amplification of multiple voices in research with any population, including kinship caregiving families. The current study is a good example of the benefits of using multiple methods (quantitative and qualitative), hearing multiple voices (caregivers, children, parents), and valuing these multiple perspectives in building knowledge and informing policy, practice and future research. We believe that researchers and those who commission research should pay attention to Bowman's (1983) recommendations that to be relevant, research requires significant involvement of those who are the focus of the research, in all phases of the research process. We believe that children, caregivers, parents, other family members, professionals, and others who experience kinship care should be involved

in defining research questions, designing studies, overseeing the implementation of the research, and interpreting the findings. This involvement is essential in carrying out research that is useful in shaping programs, policies, and interventions that may be relevant to kinship caregiving families.

We believe that research should be used to evaluate the effectiveness of existing policies and programs but also to assist in designing creative solutions to problems experienced by kinship caregiving families; creative solutions that take the form of programs and interventions to support children and families. While we believe that research should assess outcomes of policies, programs and interventions, we also believe that research should be used to assess and ensure that programs and interventions are being implemented as intended, that best practices are actually being implemented appropriately (formative and process evaluations designed to enhance the interventions and services, quality assurance and quality improvement to ensure the integrity and fidelity of program services and interventions). Research should also be used to develop and assess the effectiveness of staff training, supervision, and support for child welfare practitioners and other human service professionals who should be implementing the policies, program services and interventions. We also believe that research should regularly examine unintended negative consequences so that we do not continue to implement policies, programs, services and interventions that may actually be more harmful than they are helpful to families involved in kinship care.